		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036723

Facility Name: ST VINCENT'S HOME

Address: 1440 NORTH 10TH STREET (Number) QUINCY (City) 62301 (Zip Code)

County: ADAMS

Telephone Number: 217-224-3780 **Fax #** 217-224-3857

IDPA ID Number: 37-1069446001

Date of Initial License for Current Owners: 10/01/90

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DAVID REIS **Telephone Number:** 217-228-1950

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) DAVID REIS, PRESIDENT
(Firm Name & Address) WDM COMPUTER SERVICES. INC. 1900 HARRISON STREET QUINCY, ILL 62301
(Telephone) 217-228-1950 Fax # 217-222-6053

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ST VINCENT'S HOME # 0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,846	263	2,049	15,158	8
9	SNF/PED					9
10	ICF		11,936		11,936	10
11	ICF/DD	1,339			1,339	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,185	12,199	2,049	28,433	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.69%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 11/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 17 and days of care provided 2,049

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 2005 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ST VINCENT'S HOME # 0036723 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	161,261	18,053	3,994	183,308		183,308		183,308			1
2	Food Purchase		158,671		158,671	(104)	158,567	(11,979)	146,588			2
3	Housekeeping	79,910	14,968		94,878		94,878		94,878			3
4	Laundry	63,752	10,955		74,707		74,707		74,707			4
5	Heat and Other Utilities			92,433	92,433		92,433		92,433			5
6	Maintenance	56,398	24,313	25,801	106,512		106,512		106,512			6
7	Other (specify):*											7
8	**TOTAL General Services**	361,321	226,960	122,228	710,509	(104)	710,405	(11,979)	698,426			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,200,275	141,352	2,064	1,343,691		1,343,691	(595)	1,343,096			10
10a	Therapy	4,078	446	159,252	163,776		163,776		163,776			10a
11	Activities	35,529	7,586	16,579	59,694		59,694		59,694			11
12	Social Services	65,141	43	925	66,109		66,109		66,109			12
13	CNA Training											13
14	Program Transportation		2,517		2,517		2,517	(511)	2,006			14
15	Other (specify):* SALES TAX			46	46		46	(46)				15
16	**TOTAL Health Care and Programs**	1,305,023	151,944	190,866	1,647,833		1,647,833	(1,152)	1,646,681			16
	C. General Administration											
17	Administrative	54,415			54,415		54,415	38,000	92,415			17
18	Directors Fees											18
19	Professional Services			159,394	159,394		159,394	(122,504)	36,890			19
20	Dues, Fees, Subscriptions & Promotions			34,426	34,426		34,426	(20,750)	13,676			20
21	Clerical & General Office Expenses	33,913	11,860	20,530	66,303		66,303	41	66,344			21
22	Employee Benefits & Payroll Taxes			275,522	275,522	104	275,626		275,626			22
23	Inservice Training & Education			270	270	163	433		433			23
24	Travel and Seminar			5,894	5,894	(163)	5,731		5,731			24
25	Other Admin. Staff Transportation			1,678	1,678		1,678		1,678			25
26	Insurance-Prop.Liab.Malpractice			58,707	58,707		58,707		58,707			26
27	Other (specify):*											27
28	**TOTAL General Administration**	88,328	11,860	556,421	656,609	104	656,713	(105,213)	551,500			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,754,672	390,764	869,515	3,014,951		3,014,951	(118,344)	2,896,607			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ST VINCENT'S HOME #0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			146,815	146,815		146,815		146,815			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			144,439	144,439		144,439	(4)	144,435			32
33	Real Estate Taxes			36,862	36,862		36,862		36,862			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,083	1,083		1,083		1,083			35
36	Other (specify):*											36
37	**TOTAL Ownership**			329,199	329,199		329,199	(4)	329,195			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	12,883	734	470	14,087		14,087		14,087			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	12,883	734	54,673	68,290		68,290		68,290			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,767,555	391,498	1,253,387	3,412,440		3,412,440	(118,348)	3,294,092			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ST VINCENT'S HOME # 0036723 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,979)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(595)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(46)	15		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(35,700)	19		15
16	Personal Expenses (Including Transportation)	(511)	14		16
17	Non-Care Related Fees	(6,000)	17		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,781)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (75,616)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(36,732)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (36,732)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (118,348)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ST VINCENT'S HOME

ID# 0036723

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST VINCENT'S HOME # 0036723 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,979)	0	0	0	0	0	0	0	0	0	0	(11,979)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,979)	0	0	0	0	0	0	0	0	0	0	(11,979)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(595)	0	0	0	0	0	0	0	0	0	0	(595)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(511)	0	0	0	0	0	0	0	0	0	0	(511)	14
15	Other (specify):*	(46)	0	0	0	0	0	0	0	0	0	0	(46)	15
16	**TOTAL Health Care and Programs**	(1,152)	0	0	0	0	0	0	0	0	0	0	(1,152)	16
	C. General Administration													
17	Administrative	(6,000)	50,000	0	0	0	0	0	0	0	0	0	44,000	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(35,700)	(86,804)	0	0	0	0	0	0	0	0	0	(122,504)	19
20	Fees, Subscriptions & Promotions	(20,781)	31	0	0	0	0	0	0	0	0	0	(20,750)	20
21	Clerical & General Office Expenses	0	41	0	0	0	0	0	0	0	0	0	41	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(62,481)	(36,732)	0	0	0	0	0	0	0	0	0	(99,213)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(75,612)	(36,732)	0	0	0	0	0	0	0	0	0	(112,344)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **ST VINCENT'S HOME** **#** **0036723** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4)	0	0	0	0	0	0	0	0	0	0	(4)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4)	0	0	0	0	0	0	0	0	0	0	(4)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(75,616)	(36,732)	0	0	0	0	0	0	0	0	0	(112,348)	45

Facility Name & ID Number ST VINCENT'S HOME # 0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		CARLYLE HEALTHCARE CENTER	CARLYLE	WDM HEALTHCARE	QUINCY	MGMT
CARLYLE HEALTHCARE	100	CLINTON MANOR	NEW BADEN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V	19	MANAGEMENT	120,000	WDM HEALTHCARE		31,332	(88,668)	3
4	V	19	ACCOUNTING		WDM HEALTHCARE		1,504	1,504	4
5	V	21	OFFICE SUPPLIES		WDM HEALTHCARE		41	41	5
6	V	20	LICENSE FEES		WDM HEALTHCARE		31	31	6
7	V	19	LEGAL		WDM HEALTHCARE		28	28	7
8	V	19	CONSULTANT		WDM HEALTHCARE		332	332	8
9	V								9
10	V	17	OFFICER SALARY		CARLYLE HEALTHCARE	100.00%	50,000	50,000	10
11	V								11
12	V								12
13	V								13
14	Total			$ 120,000			$ 83,268	$ * (36,732)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST VINCENT'S HOME # 0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	DOROTHY MESSICK		PRESIDENT			20	50.00		$		1
2	ANN REIS		SECRETARY			19	48.00				2
3	SUE GRAY		TREAS			20	50.00				3
4	DOROTHY MESSICK		PRESIDENT	52.00	100,000	20	50.00	WAGES	50,000	17-3	4
5	ANN REIS		SECRETARY	24.00		19	48.00				5
6	SUE GRAY		TREAS	24.00		20	50.00				6
7											7
8	ANN REIS		CLINTON MR			2	4.00				8
9											9
10	WDM HEALTH SCVS		MGMT CO						120,000	19-3	10
11											11
12	CARLYLE HEALTHCARE	OWNES ST. VINCENTS HOME		100.00							12
13								TOTAL	$ 170,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ST VINCENT'S HOME # 0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WDM HEALTHCARE INC.
Street Address: 1900 HARRISON
City / State / Zip Code: QUINCY, ILL 62301
Phone Number: (217-228-1950
Fax Number: (217-222-6053

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	MANAGEMENT FEE	MANAGEMENT FEES	383,000	2	$ 100,000	$ 100,000	120,000	$ 31,332	1
2	19	ACCOUNTING	MANAGEMENT FEES	383,000	2	4,800		120,000	1,504	2
3	19	CONSULTANT FEE	MANAGEMENT FEES	383,000	2	1,060		120,000	332	3
4	21	OFFICE SUPPLIES	MANAGEMENT FEES	383,000	2	131		120,000	41	4
5	19	LEGAL	MANAGEMENT FEES	383,000	2	90		120,000	28	5
6	20	LICENSE FEES	MANAGEMENT FEES	383,000	2	100		120,000	31	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 106,181	$ 100,000		$ 33,268	25

Facility Name & ID Number ST VINCENT'S HOME # 0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FIRST BANKERS TRUST		X	MORTGAGE	$25,473.00	04/01/99	$ 3,500,000	$ 2,787,417	04/01/2019	6.0000	$ 141,281	1
2	FIRST BANKERS TRUST		X	KITCHEN EQ LOAN	$968.58	11/05/04	50,000	40,409	11/05/2009	6.0000	2,752	2
3												3
4												4
5												5
	Working Capital											
6	FIRST BANKERS TRUST		X	HANDICAP VAN	$745.12	08/07/00	36,000		08/07/2005	8.7500	406	6
7												7
8												8
9	TOTAL Facility Related				$27,186.70		$ 3,586,000	$ 2,827,826			$ 144,439	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,586,000	$ 2,827,826			$ 144,439	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ NONE** **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number ST VINCENT'S HOME **#** 0036723 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 23,468	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 36,882	2
3. Under or (over) accrual (line 2 minus line 1).		$ 13,414	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 23,448	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 36,862	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	37,447	8
	2001	38,454	9
	2002	40,714	10
	2003	33,801	11
	2004	36,882	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST VINCENT'S HOME COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0036723

CONTACT PERSON REGARDING THIS REPORT BRENDA WHATLEY ADM

TELEPHONE 217-224-3780 FAX #: 217-224-3858

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-7-0068-000-00	NURSING HOME PROPERTY	$ 36,862.36	$ X
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 36,862.36	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number ST VINCENT'S HOME # 0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,103 B. General Construction Type: Exterior BRICK Frame FIRE RESISTIVE Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

14 DUPLUXES OR 28 COTTAGE UNITS INDEPENDENT LIVING - VILLA CATHERINE
1 COMMUNITY CENTER
10 ASSISTED LIVING UNITS - CASITA CATHERINE ASSISTED LIVING

NO EXPENSES ON SCHEDULE V AS THESE ARE ALL IN SEPARATE DIVISIONS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	114,177	1990	$ 61,500	1
2					2
3	TOTALS	114,177		$ 61,500	3

Facility Name & ID Number ST VINCENT'S HOME # 0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		1190	1976	$ 963,000	$ 32,123	30	$ 32,123	$	$ 486,514	4
5	23		1998	1998	878,056	31,645	30	31,645		220,950	5
6											6
7											7
8											8
	Improvement Type**										
9	LAUNDRY ROOM			1999	68,109						9
10	GLASS ENCLOSER			1990	2,972	149	20	149		2,251	10
11	DINNING ROOM ADDITION			1991	86,996	4,349	20	4,349		63,800	11
12	GARAGE			1991	35,000	2,388	15	2,388		34,204	12
13	LAND IMPROVEMENTS			1991	13,130					13,130	13
14	CONCRETE DRVWY LOT 1			1993	10,580	716	15	716		8,553	14
15	FIREWALL			1993	1,808	91	20	91		1,171	15
16	CONCRETE DRVWYLOT 2			1997	83,961	5,638	15	5,638		46,071	16
17	NEW ROOF			1997	141,503	4,733	30	4,733		37,762	17
18	LANDSCAPING			1997	10,358	697	15	697		5,536	18
19	ROOFTOP A/C UNITS			1997	6,995					6,995	19
20	HANDRAILS			1998	11,165	751	15	751		5,905	20
21	WALKIN FREEZOR			1998	10,485	1,475	8	1,475		10,116	21
22	REMODELING HALLWAYS			1998	26,569	2,709	10	2,709		18,679	22
23	FIRE DAMPERS			1999	7,122	722	10	722		4,353	23
24	8 PATIENT ROOM REMODELING			1999	11,018	740	15	740		4,417	24
25	LEVEL BUILDING			2000	74,150	3,743	20	3,743		20,811	25
26	DOORS CLOSERS,NEW VENTILATION, ELECTRICAL			2000	15,450	1,039	15	1,039		5,874	26
27	RAILING			2000	2,997	382	8	382		2,010	27
28	WATER HEATER			2000	4,851	620	8	620		3,610	28
29	LAND IMPROVEMENTS			2001	4,522	304	15	304		1,310	29
30	NEW KITCHEN			2001	55,641	3,662	15	3,662		14,663	30
31	A/C COMPRESSOR			2002	5,121	649	8	649		2,170	31
32	SMOKE DECTORS			2002	2,562	324	8	324		1,021	32
33	GENERATOR			2002	4,902	621	8	621		1,902	33
34	NEW HOT/COLD WATER LINES 100/200 WINGS			2005	29,851	165	30	165		165	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ST VINCENT'S HOME # 0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,568,874	$ 100,435		$ 100,435	$	$ 1,023,943	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST VINCENT'S HOME # 0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 312,550	$ 38,877	$ 38,877	$	8	$ 206,226	71
72	Current Year Purchases	48,208	1,739	1,739		8	1,739	72
73	Fully Depreciated Assets	49,323				8	49,323	73
74								74
75	TOTALS	$ 410,081	$ 40,616	$ 40,616	$		$ 257,288	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY AUTO	1998 DODGE STRATUS	2005	$ 4,000	$ 778	$ 778	$	3	$ 778	76
77	FACILITY AUTO	1994 GMC TK/PLOW	1999	12,000				5	12,000	77
78	FACILITY AUTO	2000 CHEV VAN/LIFT	2000	40,067	4,986	4,986		5	40,067	78
79										79
80	TOTALS			$ 56,067	$ 5,764	$ 5,764	$		$ 52,845	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,096,522	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 146,815	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 146,815	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,334,076	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ST VINCENT'S HOME # 0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 1,083 Description: DISHWASHER
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ST VINCENT'S HOME # 0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number ST VINCENT'S HOME # 0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ST VINCENT'S HOME **#** 0036723 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 162,405	$	1
2	Cash-Patient Deposits	2,507		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	476,954		3
4	Supply Inventory (priced at FIFO)	13,268		4
5	Short-Term Investments			5
6	Prepaid Insurance	24,214		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 679,348	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	102,750		12
13	Land	461,131		13
14	Buildings, at Historical Cost	3,809,601		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	831,779		16
17	Accumulated Depreciation (book methods)	(1,999,987)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): GOODWILL	46,125		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,251,399	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,930,747	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 102,232	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,189		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,640		31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,496		32
33	Accrued Interest Payable	14,402		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(12,274)		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 228,685	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	99,176		39
40	Mortgage Payable	2,787,418		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DEFERRED INCOME TRUSTS	677,106		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,563,700	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,792,385	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 138,262	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,930,647	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 100,581	1
2	Restatements (describe):		2
3	INCOME TAX REFUND	(321)	3
4	PRIOR YEAR ADJ	(4,857)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 95,403	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	18,595	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Villa Catherine Division	(25,265)	15
16	Other (describe) Casita Catherine Assisted Living	49,629	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 42,959	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 138,362	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,221,227	1
2	Discounts and Allowances for all Levels	12,623	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,233,850	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	68,864	6
7	Oxygen	6,897	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 75,761	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	990	12
13	Barber and Beauty Care	12,396	13
14	Non-Patient Meals	11,979	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	21,188	17
18	Sale of Supplies to Non-Patients	595	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 47,148	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SEE ATTACHED LIST	80,398	28
28a	GAIN ON SALE OF ASSET	600	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 80,998	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,437,761	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	710,509	31
32	Health Care	1,647,833	32
33	General Administration	656,609	33
	B. Capital Expense		
34	Ownership	329,199	34
	C. Ancillary Expense		
35	Special Cost Centers	14,087	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,412,440	40
41	**Income before Income Taxes (line 30 minus line 40)****	25,321	41
42	**Income Taxes**	(6,726)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 18,595	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,056	2,088	$ 53,304	$ 25.53	1
2	Assistant Director of Nursing	1,904	2,106	38,568	18.31	2
3	Registered Nurses	6,270	6,565	112,768	17.18	3
4	Licensed Practical Nurses	28,328	30,581	461,549	15.09	4
5	CNAs & Orderlies	56,511	59,151	534,086	9.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	166	212	4,078	19.24	8
9	Activity Director	1,960	2,088	20,254	9.70	9
10	Activity Assistants	2,048	2,237	15,275	6.83	10
11	Social Service Workers	4,946	5,363	65,141	12.15	11
12	Dietician					12
13	Food Service Supervisor	2,220	2,332	29,569	12.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,313	12,935	90,098	6.97	15
16	Dishwashers	4,293	4,597	41,594	9.05	16
17	Maintenance Workers	4,406	4,855	56,398	11.62	17
18	Housekeepers	9,787	10,396	79,910	7.69	18
19	Laundry	7,856	8,371	63,752	7.62	19
20	Administrator	2,055	2,088	54,415	26.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,073	3,550	33,913	9.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) BEAUTY SHOP	1,281	1,387	12,883	9.29	33
34	TOTAL (lines 1 - 33)	151,473	160,902	$ 1,767,555 *	$ 10.99	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	93	$ 3,994	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant	16	480	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,584	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	979	11-3	44
45	Social Service Consultant	18	925	12-3	45
46	Other(specify) RELIGIOUS		15,600	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	243	$ 35,562		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BRENDA WHATLEY	ADM		$ 54,415
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 54,415

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
HERMAN BODEWES	LEGAL	$ 634
WDM COMPUTER SERV	ACCOUNTING/DATA PRO	35,700
WDM HEALTH CVS INC.	MANAGEMENT SEE PG 6	120,000
ACCU-MED	MDS SOFTWARE FEES	3,060
NON ALLOW		(35,700)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 123,694

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,969
Unemployment Compensation Insurance	38,391
FICA Taxes	134,169
Employee Health Insurance	22,280
Employee Meals	104
Illinois Municipal Retirement Fund (IMRF)*	
401k Plan Exp	713
TOTAL (agree to Schedule V, line 22, col.8)	$ 275,626

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	4,533
Health Care Worker Background Check	1,140
(Indicate # of checks performed 152)	
Dues & Subscriptions	887
Ill Healthcare Assoc	5,464
Ill Secreatry of state	626
Ill HealthcareAssoc Pac	475
Advertising	
IHCA Pac	(475)
Less: Public Relations Expense	20,306
Non-allowable advertising	(20,306)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,645

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
SEE ATTACHED LIST	5,894
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,894

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ST VINCENT'S HOME # 0036723 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ST VINCENT'S HOME # 0036723 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Ill Healthcare Assoc 5464**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **475**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,482** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **104** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **11,970**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **60**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **N**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.